POLICY DIALOGUE

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MALE INVOLVEMENT

A CHALLENGE FOR THE BANGLADESH NATIONAL FAMILY PLANNING PROGRAM

Increasing the involvement of men in FP programs is a challenge. Their active participation as FP method users of vasectomy, condoms, and the traditional methods of periodic abstinence and withdrawal, as well as their supportive partnership of contracepting women is an essential element in successful programs. Particularly as program managers look beyond FP to reproductive health matters, the engagement of men is required to ensure both their own health and that of their partners. Has the Bangladesh program met the challenge of involving men?

The 1993-94 BDHS asked over 3000 men about their FP knowledge, attitudes and practice. From the data it is clear that men know about FP methods and many take an active role in decision making for adopting FP the first time. Male attitudes were generally positive about FP and also about small family size. The majority of men with three or more children did not want to have any more. From the evidence it appears that men are not more pronatalist than their wives. Particularly when compared to the 1983 Contraceptive Prevalence Survey's husband respondents, the knowledge, attitude and practice of FP increased substantially in the intervening decade.

Program managers could expect active use of male methods by husbands, or support to their wives using female methods. However, less than 2 percent of couples are protected by vasectomies and the number now being performed has plummeted to less than 1000 a month, from 25,000 in 1984. Condoms protect 3 percent of current users. Traditional methods, which also require male participation, are used by 8 percent of couples. Current use of male participation methods is 11 percent of a total current use of 45 percent, one-quarter of all users. This differs from worldwide figures where at least one-third of all couples who practice FP rely on a method that requires male participation (Spieler 1991).

This Policy Dialogue will explore the reasons for the gaps between positive attitudes and knowledge of FP, and low levels of current use of male methods. We will present arguments that indicate men's FP needs may be neglected by the program and its providers. Because men lack full access to both information and services, they cannot make informed decisions nor take active part in FP that their attitudes indicate they may be willing to take. Finally, we will pose the policy questions which need to be addressed so that the program can build on its strong foundation of male interest to increase male involvement.

What Do Men Know About Family Planning?

The 1983 Bangladesh Contraceptive Prevalence Survey elicited information directly from men for the first time. Even then nearly 100 percent of men could name at least one family planning method but most men could not name many specific methods. The pill was most known -- 73 percent mentioned it. The other methods were named by less than half of the men. The male methods, vasectomy and condoms, were known by 31 and 43 percent of men respectively. Traditional methods which require participation of men, safe period/abstinence and withdrawal were mentioned by 6 and 1 percent of all men.

A decade later significant progress has been made to increase awareness of family planning methods with knowledge of all methods increasing. The husbands' survey for the BDHS 1993-94 shows that more than 90 percent of men know about oral pills, condoms, injections and tubectomy. Vasectomy is known by 90 percent while IUD (71 percent) is the least well known of all the modern methods. Knowledge of traditional methods has also increased though the degree of increase may be overstated because of past under reporting. Periodic abstinence is known by 69 percent of men and withdrawal by 42 percent.

What Are Mens' Attitudes toward Family Planning?

A ten-year comparison is not possible since attitude was not assessed in the 1983 CPS. However, the BDHS indicates that attitudes toward family planning are positive and men are as interested as their partners in small family size. Regardless of residence, education or age, the vast majority of men approve of family planning. Even in Chittagong where the national family planning program has lowest contraceptive prevalence, 85 percent of husbands approve.

Small family size is an accepted norm for most husbands. Only one third (33 percent) of husbands with two children say that they would like more children. As the number of children increases, the desire for more children decreases dramatically. Only 8 percent of husbands who have four children say they would like to have more and this drops further to 4 percent of those with five or more children.

There is also agreement between husbands and wives on the ideal number of children a family should have. In 45 percent of cases, husbands and wives agree on the number. In 20 percent the husbands want more than the wives and in a nearly equal number of cases (22 percent) the wives would like more than the husbands. The BDHS concludes that "...husbands are not any more or less pronatalist than their wives."

How Do Men Use What They Know?

Men use what they know in two ways: (i) by being current users of condoms and vasectomy, as well as participants in the use of periodic abstinence and withdrawal, and (ii) by being supportive partners as their spouse selects and uses a contraceptive.

Reported current use of all methods increased between 1983 and 1993/94. This increase reflects the increased availability of all temporary methods, particularly through community-based distribution of oral pills, condoms, and injections. Oral pill use increased the most from 2.7 percent of all couples currently using (CPS 1983) to 17.4 percent (BDHS 1993-94).

The use of condoms and traditional methods increased. Condom use went from 0.7 percent to 3.0 percent while the use of periodic abstinence and withdrawal increased from 1.4 percent to 7.3 percent.

Vasectomy current use was reported by 0.5 percent of men in 1983 and 1.1 in 1993-94.

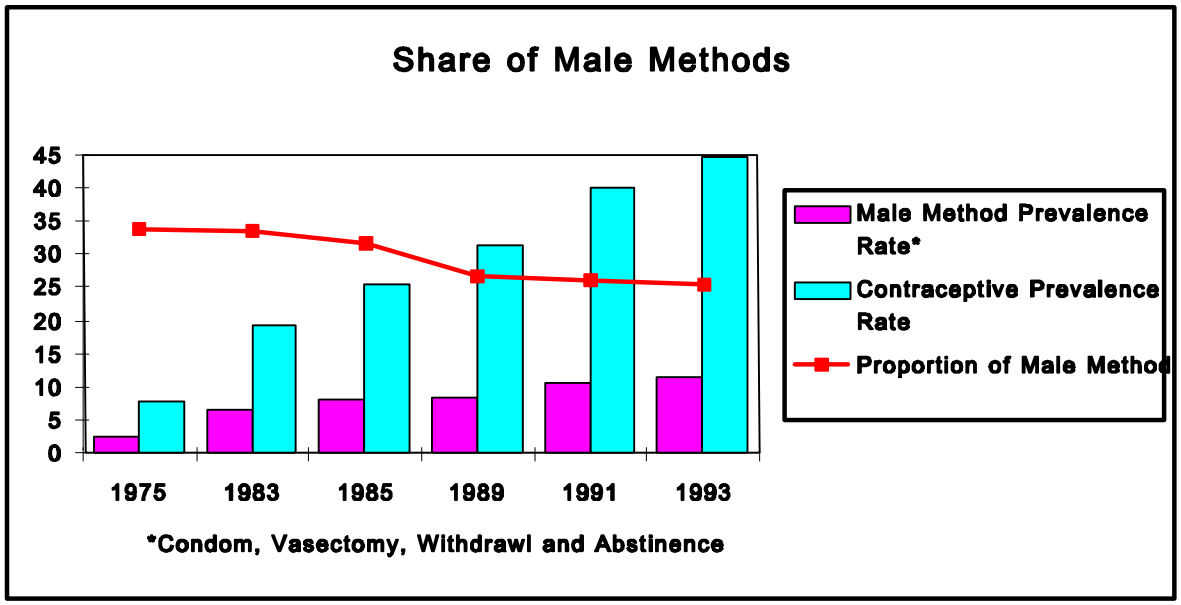
The proportional use of male participation methods over the last ten years can be seen in the graph below. In proportion to women's methods, male methods use has decreased from 34 to 26 percent of the total use. This decline needs further consideration in light of the increased knowledge that men have about family planning.

of decision making is not the norm.

Patterns of decision making change with age. Young women report that their husband has more influence in the decision. For 36 percent of married women under 20 years, their husband has more influence while in women above 35 the percentage who

49 percent of respondents say there is equal influence in the decision, whereas in Chittagong 36 percent state that the influence is equal.

Further analysis of the BDHS data indicates a positive trend regarding decision making and male participation. When women dominate the decision making 88 percent select



How Do Men Support Their Wives' Family Planning Use?

Men participate in decision making about family planning jointly with their partners in 41 percent of all cases (BDHS 1993-94). Even though joint decision making does not occur for the majority of respondents, an additional 30 percent of women say they have the greatest influence in the decision while 22 percent say that their husband is more influential. These figures indicate that male domination

cite their husband's influence as more than their own is 17 percent.

Increased education positively influences joint decision making. Women with no education say they have equal influence with their husband's in 38 percent of cases while women with secondary education or higher say that there is equal influence in 48 percent of all cases. Urban or rural residency has little influence on joint decision making. However, there is a difference in high and low prevalence areas. In Rajshahi

female methods while only 5 percent select condoms (4.2 percent) or vasectomy (less than 1 percent). However, when men have the greatest influence in decision making,
21 percent select either condoms (12 percent) or vasectomy (9 percent). This is logical as men have to be involved in the final decision to have a vasectomy.

When male dominated decision making is the norm, what kind of family size decisions might men be making? If we examine the information available on desired family size, the indication is that

men would opt for a small family and for practicing family planning to meet their family size objectives. Men approve of family planning in almost equal proportions to their partners. They approve in 92 percent of all responses while women approve in 95 percent of responses. In most cases spouses understand the perception of their partner though this is not always the case. "...in 95 percent of cases in which wives reported that their husbands approved of family planning, **the husbands also said they approved**." [BDHS 1993-94]

A clear majority of men want to limit their family size and there is agreement between spouses on the perception of ideal family size. Only 9 percent of couples with three children say they would like to have more. This percentage decreases as the number of children increase. By the time a couple has 5+ children, only 1 percent state they would like to have more.

In addition to decision making, men show support when they enable their wives to use methods. One enabling mechanism is the procurement of contraceptive supply. The sources of supply of pills for 20 percent of current users are pharmacies or shops while the source of supply of condoms is from pharmacies or shops for more than half the users (BDHS 1993-94). Further analysis indicates that husbands are the ones who purchase from the shops in 70 - 90 percent of the cases for couples who use pills or condoms.

Supportive partnership can also be defined by the actions men take when their partners have complications or side effects with their chosen method. Unfortunately, it is not clear from the information now available what role men play in the instance of contraceptive complications. The majority of women who discontinue a modern method do so because of side effects. In fact, 61 percent of IUD dropouts discontinue because of side effects and nearly 60 percent of those who stop using the injection do so because of side effects (BDHS 1993-94).

Whether well informed men, who both understand and are involved with their partners in seeking information about side effects, would lower the number of discontinuers is not known. However it is logical to assume that men who support their wives through the adjustment phase of a contraceptive could exert a positive effect on the outcome of method use.

Why Don't Men Who Know about Family Planning and Have Positive Attitudes Accept and Continue the use of Male Methods?

Even though men have knowledge and positive attitudes about using family planning methods, data on current use indicates that they are reticent to use male methods. It could be argued that the variety of male methods is so limited that the choice is, in fact, not attractive enough either to men or their wives. As a permanent method, vasectomy is only appropriate for men with completed family size while condom use is often disparaged for aesthetic reasons. Traditional methods may not be well-enough known by men for them to make informed decisions about use. The use of traditional methods requires excellent spousal communi-cation, discipline, and an understanding that method failure is high. For withdrawal the first year failure rate is 18 percent among typical users, while periodic abstinence has a 20 percent first year failure rate. By comparison, condoms have a 12 percent first year failure rate for typical users and vasectomy failure rates are less than one percent (Hatcher et al., 1992).

In a recent assessment of urban health needs (Thwin et al. 1996), men who approved male involvement in family planning commented on the problem of method choice. They expressed a need for the development of "more male methods" in the style of injectable or pills and went on to state that men "...should have full information on the merits and demerits of contraceptive use either through the media (i.e. newspapers, etc.) or by other means." Men from urban slums indicated "...a need for male involvement with reasons that they have the responsibility to decide on family size limits. They stated that they are more likely to use methods properly as women often forget to use pills correctly." At the same time, those who were against male involvement expressed concerns directly related to the male methods stating that "...condom use is unreliable" and that "...male methods -- both condoms and vasectomy -- cause men to lose energy, work less and earn less."

Men are more influential in the discontinuation of methods which involve their participation. In total only 7 percent of respondents say they stop using a method because of the disapproval of their husband. However, "husband disapproved" is the main reason given for discontinuation of condom (25 percent) and withdrawal (23 percent), and one of the reasons cited for periodic abstinence (13 percent).

Do Men Influence Non-Use of Contraceptives?

Men were not directly asked their reasons for non-use in the BDHS. However, the question was asked to non-using women. Twenty-nine percent of non-users said they have no intention of using family planning methods (BDHS 1993-94). When asked why, women under 30 stated a desire for children as the main reason for non-use (28 percent) while women over 30 responded it was difficult to get pregnant as the main reason for non-use (33 percent). Disapproval by husbands was a reason for non-use for 14 percent of women below 30 and for only 5 percent of women over 30. Women mentioned their own disapproval for non-use in only 1 percent of cases if they are
under 30 years and 0.4 percent if over 30 years. There is still a gap between what women believe and what they perceive that their husbands believe about their use of family planning.

Are Family Planning Services and Information Accessible to Men?

There is a great difference in the availability of both information and supplies for the different male methods. Condoms are readily available in outlets which men frequently visit for other purposes. The Social Marketing Company (SMC) has made it possible for men to buy condoms in more than 150,000 outlets. This is a substantial increase from a decade ago when approximately half that number of outlets were operational. Information about the use of condoms is available from the source so men can do "one stop shopping" for both information and supply.

If this information is insufficient, the wives also have access to information and supplies of condoms through the household distribution programs of government and NGOs. Thus, if men are still unwilling to purchase condoms their wives have ready access to the method.

What about access to vasectomy? In the early 1980s both male and female sterilization was a priority program. Information was available through both government field workers and private sector (self-appointed) agents. The government workers had monthly targets for sterilization clients and received a referral fee for successful recruitment of clients. Private sector agents received a referral fee as well. Both referrers were under pressure to recruit clients -- the government workers because their salaries could be withheld if the target was not reached and private agents because it was a source of livelihood for them.

Every clinical service point used by the national family planning program was prepared to serve vasectomy acceptors. For those areas where routine services were difficult to maintain, mobile camps were used. Consequently, in 1984 vasectomy performance peaked at more than 300,000.

This target-driven system and the payment for referral and service providers was abolished. While this was a necessary step toward a client-oriented/quality-motivated program, it also resulted in stagnation for the vasectomy program. Men no longer have ready access to information through either government workers or private agents nor is it easy to find a service point which provides vasectomy services. Thus in 1996, less than 1000 vasectomies are performed each month.

Data from a recent situation analysis of clinical services (Barkat, et al. 1994) shows that non-scalpel vasectomy (NSV) is available in 22 percent of Model Clinics and 5 percent of Thana Health Complexes, two

key service points for sterilization. Conventional vasectomy is provided in the majority of Model Clinics and in 68 percent of Thana Health Complexes. In 1986 all Upazila (Thana) Health Complexes and all Medical Colleges provided vasectomy services plus 93 NGO clinics and hospitals (Haq and Ahmad, 1989).

As part of the data collection for the clinical situation analysis, client-provider interactions were observed. Not one mention was made of vasectomy in any of these interactions (Barkat et al., 1994). Media materials also have not focused on vasectomy. No client-oriented materials have ever been developed in Bangladesh for NSV. In fact, the program has produced only one poster, one booklet, one sticker and one billboard on vasectomy in the past thirty years (Haider et al., 1995). The information vacuum is real and is not presently being addressed by the female field workers who serve in the CBD programs. The only male front line worker, the FPI, is involved in management and supervision of the female workers rather than in providing information to potential clients.

It could be argued that access to vasectomy services is less and certainly that information is not as readily available. In the past private sector agents and

target-driven field workers may have provided a client with only limited facts which did not lead to a fully-informed decision, but they also served as a guide through the sterilization process. Most vasectomy acceptors

received their information through these workers and were escorted to services by them. In effect, the referrer simplified the process and ensured the client received the intended service. Now that referral service no longer exists and men who are interested in vasectomy must find their own way to information and services.

For general family planning information and services, the satellite clinics have become increasingly popular in rural communities. Like the HFWC, however, the satellite clinic is a women-centered environment. Though condoms are available, it is not likely that men will attend the satellite clinic to obtain information and supplies.

The current role of private practitioners, if one exists, has not been explored. Men may be willing to use this channel for family planning services and information. However, the provision of male services may not be attractive to private practitioners who would have to invest in establishing services (i.e. vasectomy operating theater) for which there may be limited financial gain.

If Clinical Services were Revitalized, Would Men Accept Vasectomy?

AVSC International (Faisel et al.,1995) conducted a vasectomy decision making study in Bangladesh. The findings indicate that men are willing to have a vasectomy if several requirements are met. First, there must be a well-informed service provider available since most men confided in no one else about vasectomy. This was true even when they knew friends or members of their kinship group who had undergone the procedure. Second, a "spur to action" is needed. For most men the decision to have a vasectomy is made during the pregnancy or birth of the last child. Poverty is the primary "spur" for not wanting more children. Third, counseling must be provided which overcomes the fears of both the husband and wife. Wives are particularly concerned that after vasectomy their husbands will become weak or impotent. These, and other fears, must be addressed by knowledgeable providers.

Vasectomy was chosen over other methods because of the permanence, as well as dissatisfaction with other methods. The majority of vasectomized men selected vasectomy instead of tubal ligation because they were concerned about the health consequences of ligation for their wives and felt that vasectomy was an easier and/or safer operation.

A primary recommendation of the decision-making study was to encourage service providers to provide information to **all men** whom they contact. Further recommendations were to increase publicity about the advantages of vasectomy through the medium of radio, as well as promotional materials and counseling.

The quality of vasectomy services influences decision-making. Assessments of clinical services (Ahmed et al., 1992 and Barkat et al., 1994) have highlighted concerns for the delivery of all clinical methods, not exclusively vasectomy. There are supply-side problems. Some service delivery points lack the basic equipment to provide quality services. There are training gaps: "...it is clear that lack of adequate numbers of well-trained doctors and surgical teams is one of the most important factors accounting for inadequate supply and the fall-off in voluntary sterilization performance. Numerous doctors are not performing sterilizations because they have not been trained, or have received only limited on-the-job training from colleagues and therefore are not confident in performing sterilization" (Ahmed et al., 1992). These limitations negatively effect services and because of them, some service points do not provide vasectomy regularly. If FWAs and other community workers are unsure of the vasectomy services, they may discourage a potential acceptor or advise him to use a method which the worker can provide.

Policy Questions for Program Managers

The profile that is gathered from the data available is one of positive attitudes, consider-able knowledge, interest and some use of family planning methods. Yet there is also unmet need.

There are many men who state they want no more children yet do not practice a family planning method themselves nor do they assist their wives to practice.

Before their needs can be met, the national program should map out a male strategy which includes projections of the number of men to be served by the program as direct acceptors. Does the program intend to reach the worldwide standard where one-third of couples who practice family planning use a method which requires male participation? Or is another standard more appropriate?

In either case, there are key policy issues or questions which need to be addressed:

1) What should be the emphasis of a male program: supportive partnership or active acceptance and use of male methods?

2) How can access to male methods be increased in the existing clinical and CBD system?

3) What IEC channels can be used which reach men in their homes or their places of work? How is information shared both on male methods and on the experiences their part-ners will have with methods and their role in supporting that experience?

4) Is it possible to enhance vasectomy services through temporary measures while static services are upgraded?

5) Does the national program have all the information it needs about men or are there research questions which could be add-ressed, particularly on decision making about the choice of methods, as well as mens' views on quality issues in service delivery?

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Endnotes:

1. Three other reasons for discontinuation of periodic abstinence were more often cited than husband disapproved. These were: to become pregnant (32.2 percent); became pregnant (19.7 percent); and more effective method (14.5 percent). However, in the case of condom and withdrawal, the husband disapproval was cited more often than either to become pregnant or any other reason.

2. NSV is a technique of vasectomy developed in China. It improves on conventional (incisional) vasectomy because no incision is required. Other advantages are that the vas is anesthetized, making it more comfortable for the acceptor; no stitch is required; recovery is more rapid -- acceptors can leave the clinic within an hour and return to work in 2-3 days rather than 7 days for conventional procedures; complications are practically eliminated -- there is little bleeding and virtually no hematomas. NSV was introduced in Bangladesh in 1989 in both the GOB and NGO program. Master trainers in NSV is from Bangladesh and international training in NSV is conducted. Yet, only 211 doctors who work in the national program have been trained, an insufficient number to cover the service points which should provide NSV.

REFERENCES:

Ahmed, J. et al. (1992). "Assessment of Clinical Contraception Services in the Bangladesh Family Planning Program", AVSC International.

Faisel, A.J. et al. (1995). "Vasectomy Decision-Making in Bangladesh", AVSC International.

Haq, N. M. and S. Ahmad (1989). "Study of Compensation Payments and Family Planning in Bangladesh: A Synthesis", NIPORT, Bangladesh.

Haider, S.J., K. Streatfield, and M. A. Karim (1995). "Comprehensive Guidebook to the Bangladesh Family Planning-MCH Program", READ, The Population Council and Ministry of Health and Family Welfare, Government of Bangladesh.

Hatcher, Robert A. et al. (1992). CONTRACEPTIVE TECHNO-LOGY, 1990-1992, Irvington Publishers, Inc. New York.

Mitra and Associates (1985). "Bangladesh Contraceptive Prevalence Survey - 1983".

NIPORT, Mitra and Associates and DHS (1994). "Bangladesh Demographic and Health Survey: 1993-94".

Spieler, J. (1991). "Men in Family Planning" speech to AVSC Staff Workshop, New York.

Thwin, Aye-Aye et al. (1996). "An Assessment of Health Needs of the Urban Population in Bangladesh", DRAFT report, MCH-FP Extension Project, ICCDR,B.